PROJECT TO IMPROVE HEALTH PRICE TRANSPARENCY FOR TEXAS CONSUMERS

November 13, 2014

Texas Department of Insurance

AGENDA

- Project goal
- Challenges
- Revised Approach
  - Scope of services
  - Data fields
  - Consumer-focused display
- Next Steps
  - Proposed rule changes
  - Technical feedback needed

BACKGROUND

- SB 1731, enacted by the 80th Texas Legislature, provides consumers new rights to health care price transparency:
  - Health plans must provide enrollees with cost estimates upon request and notify enrollees regarding the risk for balance billing
  - Providers must provide uninsured and out-of-network patients with charge estimates upon request
  - Insurers must submit reimbursement rates in a standardized format established by TDI to allow consumers to compare average prices across geographic regions

PROJECT GOAL

Connect consumers to meaningful information on health care prices and develop resources to help consumers engage in health care purchasing decisions

THE CONSUMER

- Insured and uninsured consumers
  - Planning for health costs
  - Benchmark for comparing price estimates
  - Negotiating discounts (uninsured) or balance bills (insured)
  - Understanding need for and value provided by health insurance
  - Choosing between insurance plan designs (lower premium versus lower deductible)

CURRENT SCOPE OF SERVICES

Current scope:

- High volume services
  - Not necessarily targeted to our identified consumer
    - Most inpatient codes are driven by Medicare volume
    - Many codes are not shoppable
    - We did not focus codes on services for which consumer are price-sensitive or that are known to vary widely in cost
  - Individual codes versus treatment events

REVISED SCOPE OF SERVICES

Revised approach:

- Review best practices – what data is presented in other states and in insurer-provided tools?
- Prioritize common services for target population: uninsured or privately insured
- Focus on procedures that allow for planning and choice

PROPOSED SCOPE OF SERVICES

Proposed scope:

- Office Visits: check-ups, well-woman exams, physician care, and specialist consults for new and existing patients
- Imaging: MRIs and CT scans with and without contrast; digital and analog mammograms
- Facility Outpatient (facility, professional, anesthesia): vasectomy, hernia repair, knee and shoulder arthroscopy, endoscopy (nasal, sinus, upper and lower GI), tonsillectomy, spirometry
- Inpatient (facility, professional, anesthesia): bariatric surgery, stomach esophageal and duodenal procedure, cardiac angioplasty, coronary bypass, c-section and vaginal delivery, hysterectomy, hip and knee replacements, back surgery

SCOPE OF SERVICES

Category	Current	Proposed
Office/Professional Services	63 codes	14 visit types (44 codes)
Pathology	29 codes	?
Anesthesiology	20	17 outpatient; 10 inpatient
Imaging/Radiology (facility and professional)	93 codes + "26" modifiers	22 service types (69 codes + "26" and "TC" modifiers)
Neonatology	11 codes	?
Facility Outpatient (facility and professional)	39 codes	17 procedure types (36 codes)
Inpatient (facility and professional)	62 codes	10 procedure types/DRGs; (31 ICD-9 Procedure Codes)

INPUT ON SCOPE OF SERVICES

- Discussion
  - Are we including anything that won't be valuable to consumers?
  - Are there other services we should try to include?
- You can also submit comments via email
  - HealthPriceTransparency@tdi.texas.gov

DATA ISSUES

- Collecting data at an aggregate level produces only one data point per issuer
  - Unable to report an estimated range or the amount of variability
  - Unable to identify outliers, which may skew average
  - Limited ability to evaluate whether data is reliable
- Not collecting all necessary data fields (e.g., modifiers, units of service) and cost components (e.g., facility, professional, technical)
- Inpatient and facility outpatient procedures don't reflect full cost
  - Facility outpatient CPTs don't include full cost of care
  - Inpatient DRGs are not used by all payers
- Six-month reporting period limits the number of data points
- Aggregating at regional level limits ability to reflect market-specific rates

RECOMMENDATIONS

- Improve data accuracy and display: collect data on median and quartiles to reflect variability and avoid influence of outliers
- Collect missing data fields: update data collection form to include units of service, place of service, modifiers as appropriate
- Display full cost: group cost components into treatment events to give consumers a complete picture of the costs
- Address complexity of inpatient/outpatient facility billing: develop more detailed instructions for reporting inpatient and outpatient procedure cost components
- Double the data points: extend data reporting period to 12 months
- Reconsider the regional grouping system: collect data by 3-digit zip code, rather than 11 regions

CURRENT DATA FIELDS

- Current data collected for each code, in-network and out-of-network:
  - Total number of claims
  - Total amount billed
  - Total amount paid
  - Total amount allowed
- TDI calculates and presents a weighted average:
  - Average billed
  - Average paid
  - Average allowed

PROPOSED DATA FIELDS

- Proposed data to collect for each code, in-network and out-of-network:
  - Number unique claim IDs billed and allowed
  - Number units of service billed and allowed
  - Total amount billed and allowed
  - Median amount billed and allowed
  - Variation in billed and allowed (e.g., quartiles)
- TDI would calculate a weighted average:
  - Average billed and allowed
  - Median billed and allowed
  - Variation in billed and allowed

SAMPLE DIRECTIONS

Facility Outpatient Procedures

Report separately for in-network and out-of-network claims

Facility Fees

- Using CPT code, add all lines in a claim where the provided CPT code appears
- Limit to claims where units of service = 1

Professional Fees

- Using CPT code, add all lines in a claim where the provided CPT code appears
- Limit to claims where place of service = Outpatient Hospital or Ambulatory Surgical Center

Costs will be reported separately by place of service

*Still determining incorporation of anesthesiology fees

SAMPLE DIRECTIONS

Inpatient Procedures

Report separately for in-network and out-of-network claims

Facility Fees

- If using provided DRG grouper, aggregate all facility fees for the entire DRG, OR
- If using provided ICD-9 Procedure and Primary Diagnosis Codes, aggregate all facility fees for the entire length of inpatient hospitalization

Professional Fees

- Identify patients using either the DRG grouper or the combined ICD-9 Procedure and Primary Diagnosis Code
- For identified patients, aggregate all professional fees for the entire length of the inpatient stay

*Still determining incorporation of anesthesiology fees

SAMPLE DIRECTIONS

Outpatient Imaging Services

Report separately for in-network and out-of-network claims

Facility Fees

- Using CPT codes provided, report billed charges and allowed amounts for all facility claims
- Report claims with and without modifiers

Professional Fees

- Using CPT codes provided, report billed charges and allowed amounts for all professional claims
- Separately report claims with Modifier 26 (professional), Modifier TC (technical component), and no modifier (global)

INPUT ON DATA FIELDS

- Discussion
  - Will these fields produce data that makes sense to consumers?
  - Are there other data fields that need to be collected?
  - Alternative approaches for inpatient procedures?
- You can also submit comments via email
  - HealthPriceTransparency@tdi.texas.gov

CONSUMER DISPLAY – CURRENT

Search Results

Service Category: Professional Services - Radiology
Region: Metroplex | Region 3

KEY		
	R	SPECIFIED REGION
	S	STATEWIDE

All specified rates below are averaged

Viewing In-Network Rates | View Out-of-Network Rates

In-Network Rates

CPT or MS-DRG Code and Description	Key	Billed Charge	Contracted Rate	Amount Paid to Provider
71020 - X-ray of chest, 2 views, front and side	R	$124.77	$42.79	$28.08
	S	$156.58	$55.51	$37.08
71020 *26 - X-ray of chest, 2 views, front and side - professional component	R	$42.55	$17.14	$11.88
	S	$45.24	$18.56	$12.87

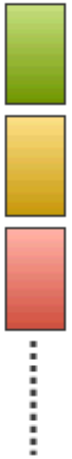
Out-of-Network Rates

CPT or MS-DRG Code and Description	Key	Billed Charge	Allowed Amount	Amount Paid to Provider
71020 - X-ray of chest, 2 views, front and side	R	$231.22	$110.45	$60.48
	S	$314.23	$179.45	$114.84
71020 *26 - X-ray of chest, 2 views, front and side - professional component	R	$49.47	$25.26	$16.00
	S	$57.04	$25.24	$15.66

MODEL: HOSPITAL COMPARE

- Why these measures are important
- More information about the data
- Current data collection period

Legend:



Better than U.S. National Rate

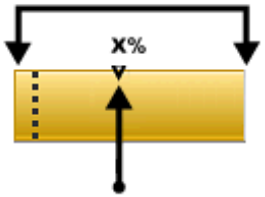
No different than U.S. National Rate

Worse than U.S. National Rate

U.S. National Rate

Range of uncertainty around the facility's ratio

Interval Estimate



Estimated risk-adjusted rate

Hover over the caret to view interval estimate range

MODEL: HOSPITAL COMPARE

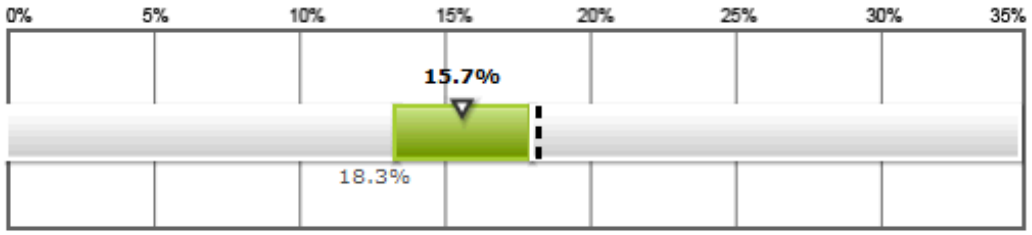
Rate of unplanned readmission for heart attack patients

Why is this important?

Hide Graph

← Lower Percentages Are Better ←

Hover over the caret to view interval estimate range



ST LUKES EPISCOPAL HOSPITAL

Number of included patients:

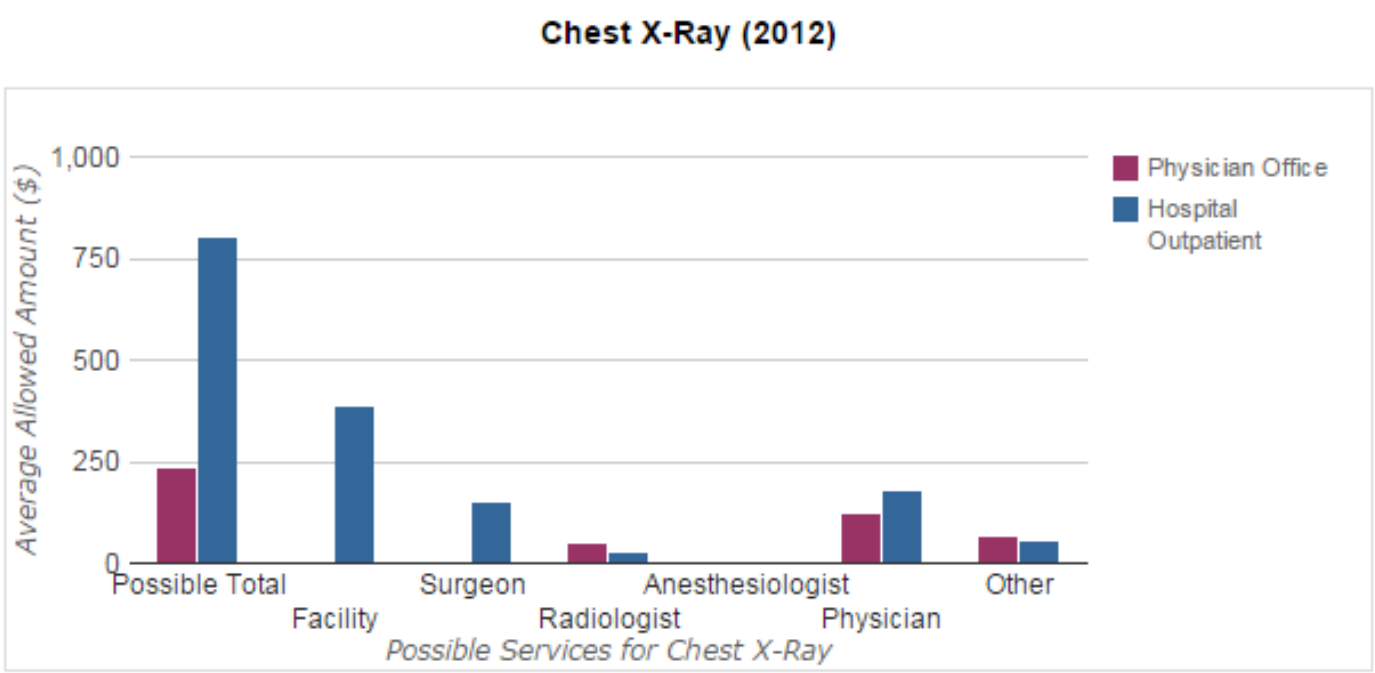
448

U.S. national rate of unplanned readmission for heart attack patients = 18.3%

MODEL: VIRGINIA

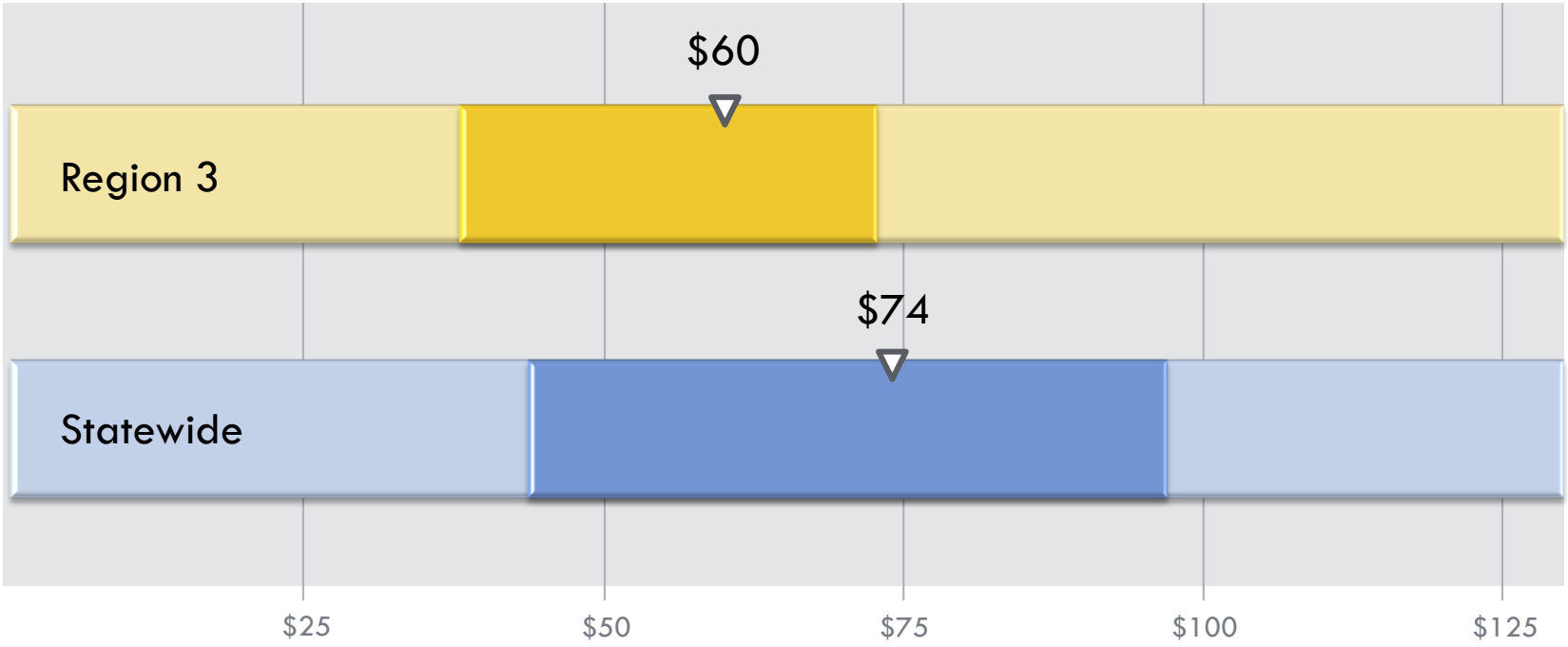
	Average Allowed Amounts for possible services associated with this procedure Your care may not require all possible services for Chest X-Ray						
Locations	**Possible Total ▼**	Facility	Surgeon	Radiologist	Anesthesio-logist	Physician	Other Charges
Physician Office	**$238**	◆	◆	$48	◆	$125	$65
Hospital Outpatient	**$802**	$388	$149	$29	◆	$179	$57

◆ - Too few health insurance carriers reported information to calculate



CONSUMER DISPLAY – PROPOSED

Chest X-Ray (Facility + Professional)			
	Facility	Professional	Total
Region 3	$43	$17	$60
Statewide	$56	$19	$74



INPUT ON CONSUMER DISPLAY

- Discussion
  - Is the median the correct number to display?
  - Does it provide value to display a range?
- You can also submit comments via email
  - HealthPriceTransparency@tdi.texas.gov

NEXT STEPS

- Data collection form and instructions
  - Assemble technical working group for input and testing
  - Incorporate feedback
- Rule
  - Draft amendments to reflect changes in data collection approach
  - Solicit input on informal draft (Spring)
  - Develop rule proposal (Summer)

PROPOSED RULE CHANGES

Consider changes to rule at 28 TAC Chapter 21, Subchapter KK

- Reporting period: modify from 6 months to 1 year
- Geographic regions: collect data by 3-digit zip code, rather than 11 health care regions
- Applicable companies: move cut-off from 10,000 lives (in HMO or PPO) to 20,000 lives (per NAIC Supplemental Health Care Exhibit)
- Consider excluding HMO claims
- Specify procedures on which data will be collected (with flexibility to incorporate coding changes (e.g., ICD-10)
- Specify data fields on which data will be collected
- Allow issuers to use a third party to process claims data in specified format

FEEDBACK REQUESTED

- Willing to participate in technical working group to refine data collection form and instructions?

- Contact us:
  - HealthPriceTransparency@tdi.texas.gov
  - Rachel Bowden – 512-305-7323